1. Purpose

1.1 The purpose of this paper is to inform on the position of the Trust in relation to infection prevention and control during June and July 2010.

2. New Developments

2.1 We welcome the new director of infection prevention and control, Miss Eiri Jones and look forward to working with her.

2.2 The infection prevention and control team would like to thank our outgoing Chief Executive Officer, Mrs Jean O'Callaghan for her support and commitment to patient safety and in particular to the improvements we have made in reducing the risk of cross-infection at Bedford Hospital.

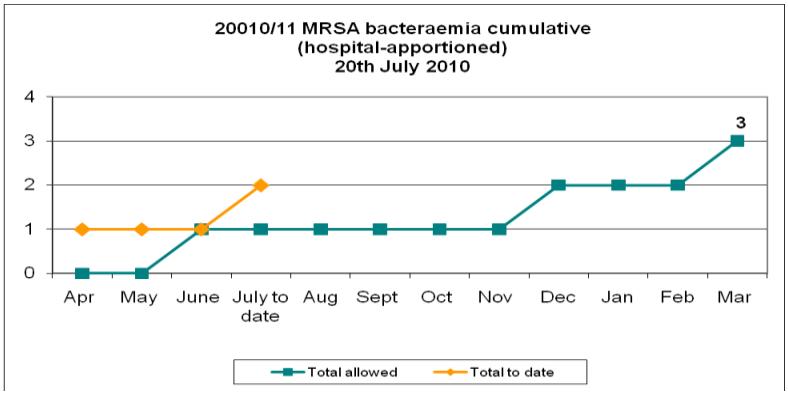
2.3 The revision to the NHS Operating Framework for 2010/11, published in June, states the following about healthcare-associated infection reduction:

> "NHS organisations have achieved significant reductions in MRSA bacteraemias and *Clostridium difficile* infections. Organisations should demonstrate continuous improvement as per the new standards, while pursuing a zero tolerance approach to infections. There are no changes to how we expect each organisation to deliver and, as part of opening up data to the public, the Health Protection Agency has been asked to publish data on a weekly basis from 5 July 2010."

This statement supports our vision of "no avoidable infections".

3. Performance

3.1 MRSA Bacteraemia



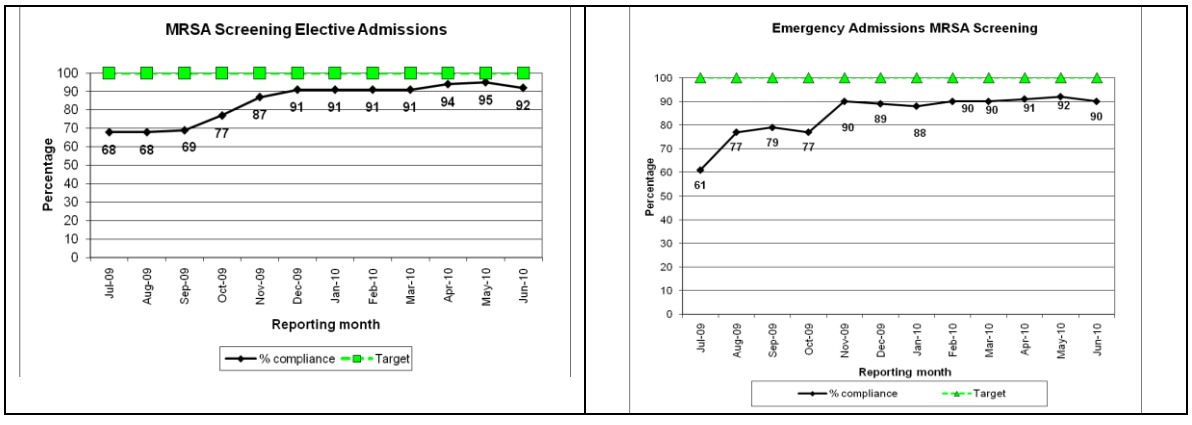
We recorded our second hospital-apportioned MRSA bacteraemia of the year in July. At time of writing, the root cause analysis of this case is not complete, but the patient was not known to be colonised with MRSA prior to the positive blood culture. The case arose in the medical division. In order to ensure that the hospital achieves its reduction target this year prevention of further cases must be given high focus.

3.2 MRSA screening.

We continue to struggle to achieve 100% compliance with MRSA screening. Key risk areas for elective screening are patients who attend without pre-operative assessment, erroneous recording of screening results on the pathology system (so they are not seen when the database is interrogated to match screen to patient) and patients who may attend the hospital several times in one month.

We have extended and enhanced systems to ensure that patients are screened appropriately, including use of a web-based tool that highlights elective patients without a valid MRSA screen. The board should expect to see a significant improvement next month.

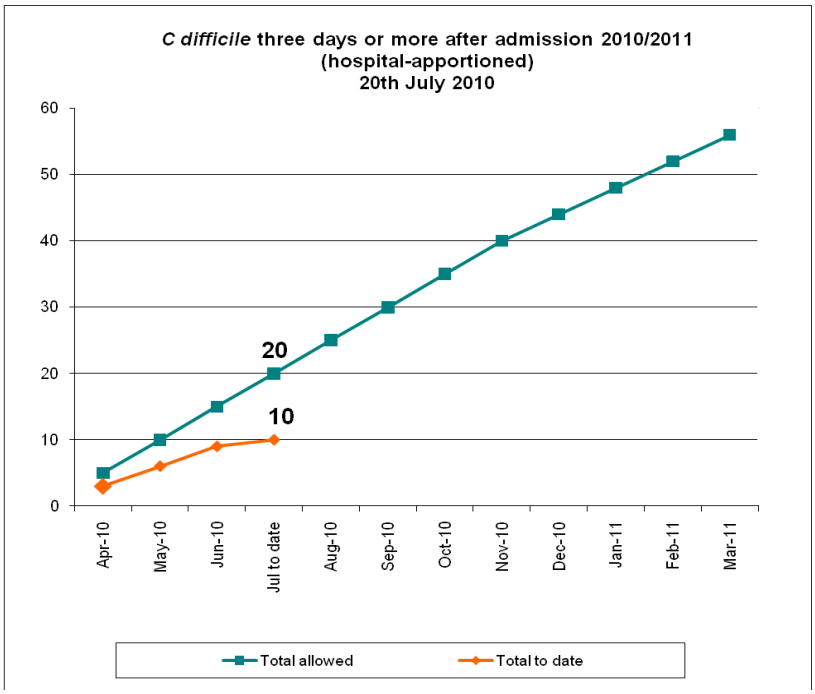
Admission MRSA screening for emergency inpatients must be 100% compliant by 31st December 2010. Current actions include instigation of a manual check on the day of admission and again, the board should expect to see significant improvement.

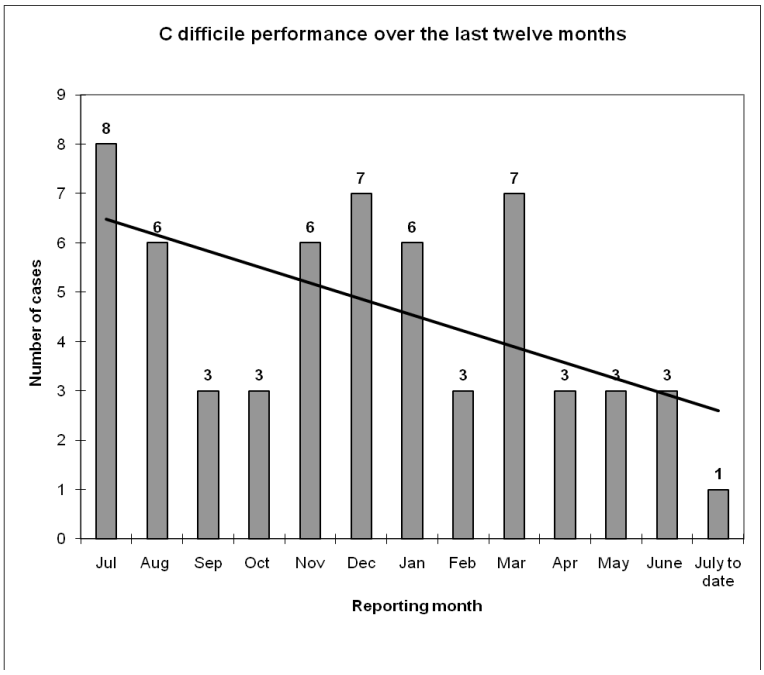


3.3 *Clostridium difficile*

Our incidence of patients developing *Clostridium difficile* associated disease has fallen significantly so far this year. We have a ceiling of **56** cases for 2010/11,

and finished Q1 at **9** cases against a ceiling of **15**. Our twelve month projection, based on the last twelve months, is **58** cases. However, if the current good performance can be maintained, it will be possible to improve on this considerably.





Time to isolation

The correct and timely placement of infected patients (suspected or proven infection) into single rooms can be very effective in reducing the overall numbers of infected patients; it can also reduce the risk of colonisation in other patients within the ward. Isolation practices can also be carried out within the ward areas; this is called 'cohorting' (for example Harpur Cohort ward for patients with *Clostridium difficile* associated disease. Through such measures, it is possible to control the spread and minimise the impact of infections such as MRSA, *C. difficile* and other healthcare-associated infections.

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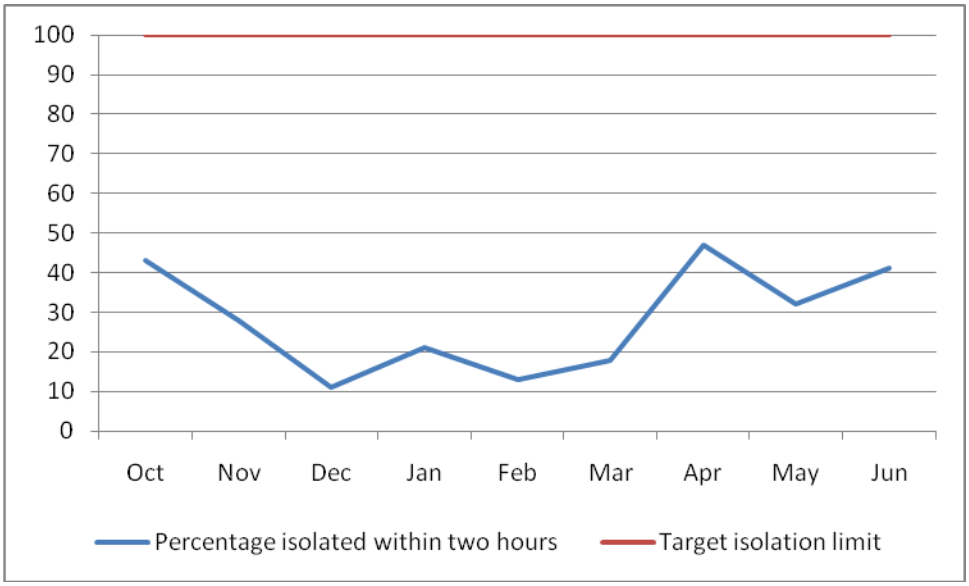
Gold standard infection control advice is to isolate the patient immediately the need is recognised, and high-clean the bed space. The standard time limit set by the Strategic Health Authority for isolation of patients with alert organisms or infections is two hours.

Using the ExtraMed system, we can now measure how long it takes to isolate a patient. The infection control team flags that the patient needs isolation and then contacts the bed manager to request this. The bed manager can then record what time the patient was moved (this can also be done retrospectively). The following charts show the trend over time (October 2009 – June 2010) of patients isolated within two hours.



The key barrier to achieving better compliance with prompt isolation is bed occupancy, particularly in the medical division. High bed occupancy means that there is unlikely to be a single room already available for the patient, and a series of moves of patients and high-cleans must take place to enable isolation. It is not

uncommon that there is not a bed for the person no longer needing a single room to move to, and this further delays isolation of the infected patient.

Furthermore, movement of patients between wards is a risk to continuity of care, as it is possible that the patients' consultant will change, and the patient and family will be unfamiliar with the new ward team.

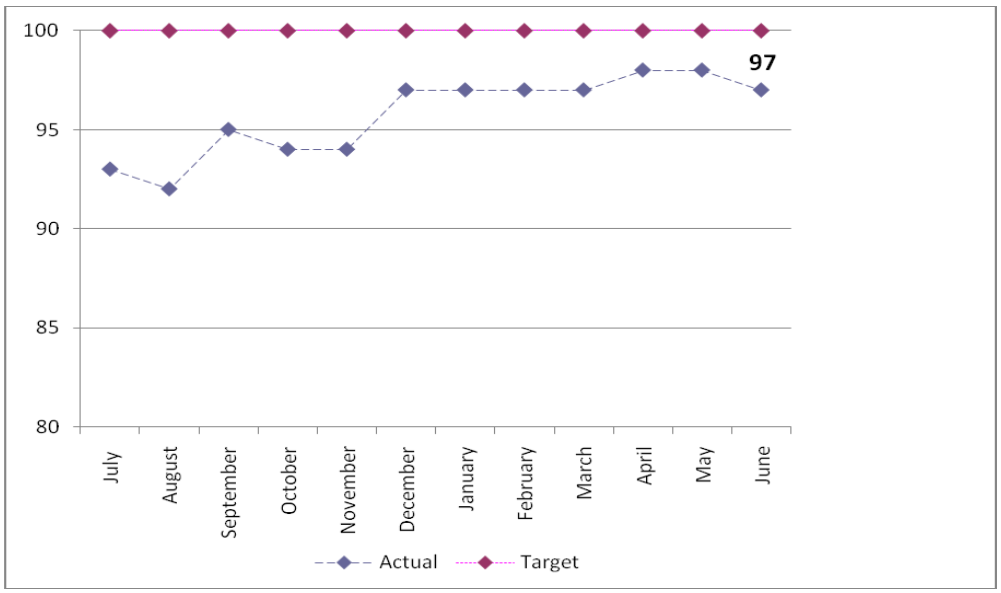
The medical matrons and infection control nurses have investigated use of MRSA cohort bays. These have worked well when demand on beds is lower, but as activity increases, pressure to admit patients dictates that it is not feasible to have ring-fenced beds in bays. There is further pressure on the nursing workforce, as we recommend that in line with advice from the Department of Health, there is a designated nursing team for any cohort bay.

Sixteen per cent of our adult bed capacity is single rooms (excluding specialist beds such as coronary care and critical care). This appears to be average across the region.

To increase the likelihood of a patient isolated within two hours, the following needs to be considered:

- Reducing bed occupancy in the medical division
- Increasing "special cleans" capacity to speed up high-cleans
- Commitment to and resources for MRSA cohort bays

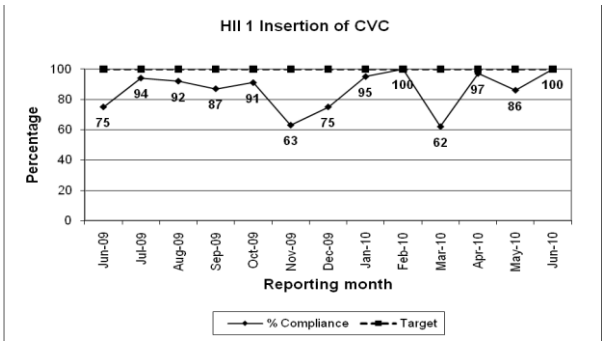
3.4 Hand Hygiene

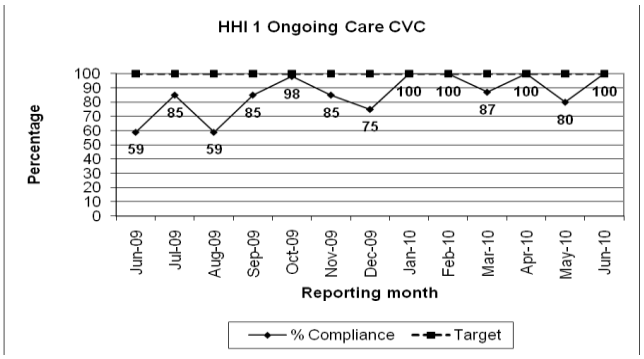


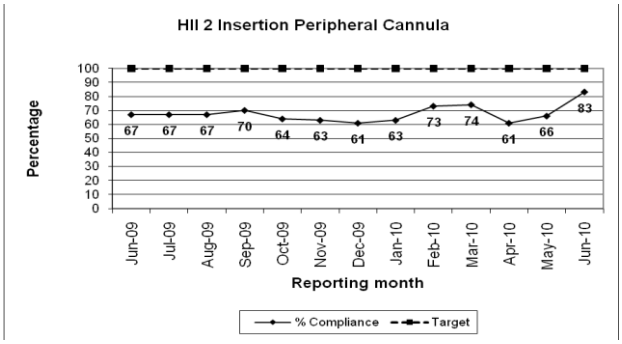
The audit tool monitors the five moments for hand hygiene. The infection control team is currently reviewing the audit process and inter-rata reliability and will report this to the September board.

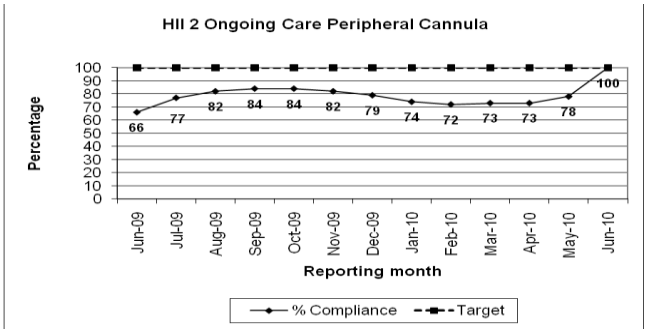
We are taking part in the Bedford River Festival to teach and promote good hand hygiene to the general public.

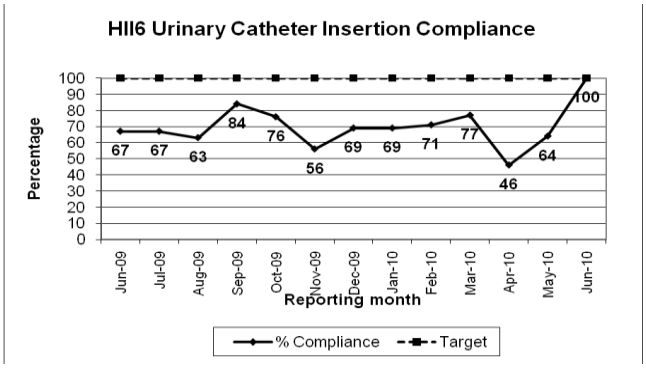
4. High Impact Interventions

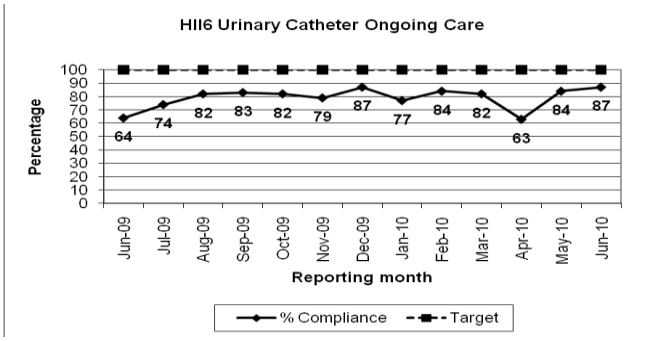












We saw an improvement last month in the monitoring returns to the infection control team, which is reflected in the improved compliance as there is a larger sample size. We are addressing wards and departments that persistently do not submit monitoring data and ask for the board's endorsement of this.